Dawes Fretzin Clinical Research Group, LLC
360 Plaza Drive, Suite C
Columbus, IN 47201

Patient Name: _____ **Date of Birth:** _____ **Date:**_____

SELF REPORTED PERSONAL MEDICAL HISTORY

For DFCRG informational purposes only. Information is self-reported and not all inclusive

PLEASE LIST ALL MEDICAL CONDITIONS INCLUDING DATE OF DIAGNOSIS:

Yes	No		Date
		Cardiovascular	
☐	☐	High Blood Pressure	_____
☐	☐	High Cholesterol	_____
☐	☐	Congestive Heart Failure	_____
☐	☐	Heart Attack	_____
☐	☐	Irregular Heart Rhythm	_____
☐	☐	Heart Valve Disease/Replacement	_____
☐	☐	Defibrillator/Pacemaker	_____
		Pulmonary	
☐	☐	Asthma	_____
☐	☐	Emphysema	_____
☐	☐	Tuberculosis	_____
☐	☐	COPD	_____
		Renal/Kidney	
☐	☐	Renal Insufficiency	_____
☐	☐	Dialysis	_____
☐	☐	Kidney Stones	_____
		Liver/Gastrointestinal	
☐	☐	Hepatitis	_____
☐	☐	Cirrhosis	_____
☐	☐	Gall Stones	_____
☐	☐	Peptic Ulcers	_____
☐	☐	Ulcerative Colitis	_____
☐	☐	Irritable Bowel syndrome	_____
☐	☐	GERD	_____
☐	☐	Crohn's disease	_____
		Skin	
☐	☐	Psoriasis	_____
☐	☐	Acne	_____
☐	☐	Rosacea	_____
☐	☐	Atopic Dermatitis/Eczema	_____
		Females	
☐	☐	Surgically Sterile	_____
☐	☐	Birth Control	_____
☐	☐	Postmenopausal	_____
		Last Menstrual Cycle	_____

Yes	No		Date
		Eye	
☐	☐	Cataracts	_____
☐	☐	Glaucoma	_____
		Neurologic/Psychiatric	
☐	☐	Seizures/Epilepsy	_____
☐	☐	Stroke	_____
☐	☐	Migraines	_____
☐	☐	Suicide attempt	_____
☐	☐	Depression	_____
☐	☐	Anxiety	_____
		Endocrine	
☐	☐	Hypothyroid	_____
☐	☐	Hyperthyroid	_____
☐	☐	Diabetes Type I	_____
☐	☐	Diabetes Type II	_____
		Musculoskeletal	
☐	☐	Osteoporosis	_____
☐	☐	Rheumatoid Arthritis	_____
☐	☐	Psoriatic Arthritis	_____
☐	☐	Osteoarthritis	_____
		General	
☐	☐	Insomnia	_____
☐	☐	AIDS/HIV+	_____
☐	☐	Hepatitis B or C	_____
☐	☐	Gout	_____
☐	☐	Seasonal Allergies	_____
☐	☐	History of Cancer	_____
		Type: _____	
		Males	
☐	☐	Vasectomy	_____
☐	☐	Partner post menopause	_____
☐	☐	Partner Surgically sterile	_____

Contraception Method:_____

Alcohol Use: ☐ Yes ☐ No If Yes: How many drinks _____ Per Week / Month/Year How Long:_____years
What type: ☐ Beer ☐ Wine ☐ Liquor

Tobacco Use: ☐ Yes ☐ No If Yes: How many ____ Per Day / Week How Long:_____years
What type: ☐ Cigarettes ☐ Cigars ☐ Pipe

Any other medical history not previously addressed: _____

_____

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PREVIOUS SURGERIES

Name of Surgery:	Date:	Reason:
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____

MEDICATIONS (Including all over the counter medications, vitamins and supplements)

Medication Name:	Dosage:	Reason taken:	Start Date:
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____
7. _____	_____	_____	_____
8. _____	_____	_____	_____
9. _____	_____	_____	_____
10. _____	_____	_____	_____

ALLERGIES TO MEDICATIONS

1._____ 2._____ 3._____

4._____ 5._____ 6._____

PRIMARY CARE PHYSICIAN **May we contact your primary care physician?** ☐ Yes ☐ No

Physician's Name: _____ Phone Number: _____

Address: _____

CONSENTS FOR PARENT(S)/LEGAL GUARDIAN(S) OF MINOR PATIENTS ☐ N/A

FOR ALL MINOR PATIENTS:

Do you consent to allowing other adults (over the age of 18) to bring your child to appointments to conduct protocol-specified procedures, following the screening and enrollment visits, and to visits where re-consent is not required?

☐ Yes ☐ No PARENT/LEGAL GUARDIAN INITIALS: _____

FOR PATIENTS WHO ARE ≥ 16 YEARS OF AGE: ☐ N/A

Do you consent to allowing your child, who is ≥ 16 years of age, to attend appointments alone to conduct protocol-specified procedures, following the screening and enrollment visits, and to visits where re-consent is not required?

☐ Yes ☐ No PARENT/LEGAL GUARDIAN INITIALS: _____

Completed By – Patient Signature: _____ Date: _____

Reviewed By – Study Coordinator Signature: _____ Date: _____